1. Inpatient Hospital Services (Continued)

Inpatient Psychiatric Hospital Services For Individuals Under 22 Years of Age (Continued)

Sexual Offender Programs

Sexual Offender Programs are designed specifically for the treatment of those patients designated as sexual offenders who cannot be treated with other mental health patients. These services are provided in separate units in the psychiatric hospital. These units meet all the requirements of Subpart D of 42 CFR Part 441 for inpatient psychiatric services for individuals under 21. In addition, they must meet any certification requirements of the Division of Mental Health Services.

Effective for cost reporting periods beginning on or after September 1, 1995, these providers will be reimbursed using Medicare Principles of Reasonable Cost Reimbursement, in 42 CFR Part 413, subject to cost settlement. The initial interim rates for these programs will use reasonable budgeted cost reports. Once audited cost reports are available the most recent audited cost report will be used to set the interim rate. Interim rates will be adjusted every six months if costs increase more than 10%.

Year end cost reports must be submitted and will be audited in the same manner as audits for inpatient psychiatric hospitals and will be cost settled.

STATE Arkansas
DATE 07-20-95
DATE 10-10-95 A
DATE EFF 09-01-95
HCFA 179 95-22

SUPERSEDES: NONE - NEW PAGE

1. Inpatient Hospital Services (Continued)

Annual Cost Report

Each hospital participating in the Arkansas Medicaid Program shall submit an annual cost report following Medicare's principles of cost reimbursement. Said cost report shall be submitted within five (5) months after the close of the fiscal year end. Failure to file the cost report within the prescribed period, except as expressly extended by the State Medicaid agency, shall result in suspension of reimbursement until the cost report is filed.

Access to Subcontractor's Records

When the facility has a contract with a subcontractor, e.g., pharmacy, doctor, hospital, etc., for services costing or valued at $10,000 or more over a 12-month period, the contract must contain a clause giving the Department access to the subcontractor's books. Access must also be allowed for any subcontract between the subcontractor and an organization related to the subcontractor. The contract shall contain a provision allowing access until three years have expired after the services have been furnished.

STATE Arkansas
DATE REC'D FEB 2 3 1996
DATE APP'D APR 1 8 1996
DATE EFF APR 0 1 1996
HCFA 179 96-03

A

SUPERSEDES: TN • 91-20

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

Revised: November 1, 1995

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1. Inpatient Hospital Services (Continued)

Audit Function

Under a common audit agreement, the Medicare intermediary performs any audit required for both Title XVIII and XIX purposes. However, the Medicaid Program may choose to audit even though Medicare does not.

Rate Appeal and/or Cost Settlement Process

A medical facility administrator may request reconsideration of a Program decision by writing to the Assistant Director, Division of Medical Services. This request must be received within 20 calendar days following the application of policy and/or procedure or the notification of the facility of its rate. Upon receipt of the request for review, the Assistant Director will determine the need for a Program/Provider conference and will contact the facility to arrange a conference if needed. Regardless of the Program decision, the provider will be afforded the opportunity for a conference if he/she so wishes for a full explanation of the factors involved and the Program decision. Following review of the matter, the Assistant Director will notify the facility of the action to be taken by the Division within 20 calendar days of receipt of the request for review or the date of the Program/Provider conference.

If the Assistant Director's, Division of Medical Services, decision is unsatisfactory, the facility may then appeal the question to a standing Rate Review Panel established by the Director of the Division of Medical Services which will include one member of the Division of Medical Services, a representative of the Arkansas Hospital Association and a member of the DHS Management Staff who will serve as chairman.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

Revised: November 1, 1995

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1. Inpatient Hospital Services (Continued)

Rate Appeal Process (Continued)

The request for review by the Rate Review Panel must be postmarked within 15 calendar days following the notification of the initial decision by the Assistant Director, Division of Medical Services. The Rate Review Panel will meet to consider the question(s) within 15 calendar days after receipt of a request for such appeal. The question(s) will be heard by the panel and a recommendation will be submitted to the Director of the Division of Medical Services.

STATE Arkansas
DATE REC'D SEP 14 1995
DATE APPV'D OCT 27 1995
DATE EFF NOV 01 1995
HCFA 179 95-26
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SUPERSEDES: TN • 95-16

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

Revised: July 15, 1998

1. Inpatient Hospital Services (Continued)

Out-of-State Hospital Reimbursement

Reimbursement rates for out-of-state hospital inpatient services (except bordering cities - see Attachment 4.19-A page 3a) will be calculated/adjusted annually. The rate year is the calendar year. The in-state hospital cost reports received by the Division of Medical Services (DMS) during a calendar year will be used to calculate reimbursement rates effective for the following calendar year. For Example:

> **Effective 5/1/98, all audited cost reports received by DMS as of 9/30/97 will be used to calculate the reimbursement rates for the next calendar year (1998).**

In order to determine reimbursement rates for out-of-state hospital inpatient services, except bordering cities (see Attachment 4.19-A, Page 3a), out-of-state hospitals will be class-grouped according to bed size. The class groups are as follows:

Group Number	Bed-Size
1	Over 300
2	151 - 300
3	101 - 150
4	51 - 100
5	0 - 50

Reimbursement by Class Group

Reimbursement rates for all class groups are set at the 40th percentile of all in-state hospitals' interim per diem rates with the same bed size group, with no cost settlement.

The rates and Medicaid days associated with in-state university-affiliated teaching hospitals are excluded when calculating the base rate for Out-of-State hospitals.

STATE Arkansas
DATE RECD July 17, 1998
DATE APPVD September 2, 1998
DATE EFF July 15, 1998
HCFA ID 98-017

A

SUPERSEDES: TN - Same 98-02

1. Inpatient Hospital Services (Continued)

Out-of-State Hospital Reimbursement (Continued)

University-affiliated Teaching Hospitals

Special consideration is given to university-affiliated teaching hospitals due to the higher costs associated with such hospitals. The rates for Out-of-State university-affiliated teaching hospitals are established at 105 percent of the 40th percentile rate of all in-state hospitals' per diem rates within the same bed size group, with no cost settlement.

In order to qualify as a university-affiliated teaching hospital, a hospital must submit documentation to the Arkansas Medicaid Program substantiating that the hospital is university-affiliated and maintains at least three different intern speciality training programs.

Hospitals Serving a Disproportionate Number of Medicaid Eligibles

Special consideration is given for hospitals serving a disproportionate number of Medicaid eligibles. **Rates for hospitals serving a disproportionate number of Medicaid eligibles are established at 150 percent of the 40th percentile rate of all in-state hospitals' interim per diem rates within the same bed size group, with no cost settlement.**

In order to qualify as a hospital serving a disproportionate number of Medicaid eligibles, a hospital must submit documentation (i.e. cost report data) verifying that Medicaid days exceed 20 percent of the total hospital days.

STATE AR DATE REC'D 3-17-98 DATE APPV'D 5-26-98 DATE EFF 5-1-98 HCFA 179 98-02	A

SUPERSEDES: TN - 91-20

2. Disproportionate Share Payment

Hospitals eligible for disproportionate share payment are acute care, inpatient psychiatric and rehabilitative hospitals in Arkansas or commonly used out-of-state hospitals (border city hospitals). Eligibility will be determined annually by the Department of Human Services and/or the State Medicare intermediary. The disproportionate share payment will be effective July 1, 1988.

Hospital cost reports and questionnaires will be used to determine disproportionate share payment eligibility in the first year. Subsequent years' questionnaire information regarding inpatient revenues, care subsidies from state and local governments, charges directly attributable to charity care and obstetrical staffing information, cost of services to Medicaid patients and cost of services to uninsured patients to establish the disproportionate share limit, etc., will be included with the cost report when submitted by the hospitals to the State Medicaid Office. The Department of Human Services will develop a standardized worksheet requesting this additional information which will be included with the cost report.

Hospital cost reports ending in the previous state fiscal year and corresponding revenue and charges information will be used to determine disproportionate share payment eligibility for the state fiscal year ending June 30th.

EXAMPLE

Disproportionate Share Payment For State Fiscal Year	**Determined From 12 Month Hospital Cost Report Ending**
1996 (7-1-95 - ~~6-30-96~~)	**Anytime between 7-1-94 - 6-30-95**

STATE Arkansas
DATE RECD FEB 23 1996
DATE APPVD APR 18 1996
DATE EFF APR 01 1996

A

SUPERSEDES: TN • 95-15

2. Disproportionate Share Payment (Continued)

Disproportionate share settlement payment to eligible hospitals will be made when the cost report is desk reviewed. This settlement payment will be calculated based on desk reviewed cost report information and statistics. This desk reviewed payment is considered to be final and no further adjustments will be made.

The four minimum criteria that a hospital must meet annually in order to qualify for disproportionate share payments are listed below. These criteria must be met during the cost report period ending in the previous state fiscal year. A hospital must meet all four criteria to be eligible to receive disproportionate share payment.

1. **A full twelve month cost report period ending in the previous state fiscal year.** Hospitals with cost report periods of less than one year will under no circumstances be eligible for disproportionate share payment. Hospital statistical information from cost report periods of less than one year will not be included in determining the Medicaid inpatient utilization rate criteria described in #2 on pages 14 and 15. Out-of-state hospitals with 850 or less Medicaid paid days by the Arkansas Department of Human Services for dates of service during the hospital's cost report period will not be eligible to receive disproportionate share payment.

STATE Arkansas
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DATE EFF APR 0 1 1996
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SUPERSEDES: TN • 95-12

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -
INPATIENT HOSPITAL SERVICES

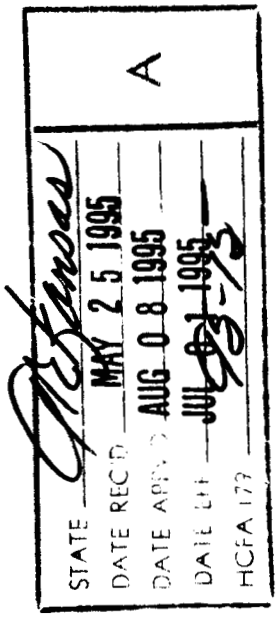
Revised: July 1, 1995

2. Disproportionate Share Payment (Continued)

2. Rural Hospitals - A Medicaid inpatient utilization rate at least one-half standard deviation above the mean Medicaid inpatient utilization rate for all in-state hospitals (See A), or a low income utilization rate (See B) exceeding 25%. See #3 definition of Rural Hospital.

Urban Hospitals - A Medicaid inpatient utilization rate at least one standard deviation above the mean Medicaid inpatient utilization rate for all in-state hospitals (See A), or a low income utilization rate (See B) exceeding 25%. See #3 definition of Urban Hospital.

Only hospitals physically located in the State of Arkansas, cost report inpatient statistics will be used to determine the mean Medicaid inpatient utilization rate.



(A) For a hospital, the Medicaid inpatient utilization rate is the total number of its Medicaid covered inpatient days in a cost reporting period divided by the total number of the hospital's inpatient days in that same period. This information will be taken from the hospital's cost report.

The Medicaid utilization rate (MUR) formula is specified in §1923(b)(2) of the Social Security Act. This formula is generally computed as follows:

MUR % = 100 x M/T

M = Hospital's number of inpatient days attributable to patients who for these days were eligible for Medical Assistance under the State Plan

T = Hospital's total inpatient days

SUPERSEDES: TN. 91-22

2. Disproportionate Share Payment (Continued)

In calculating the Medicaid inpatient utilization rate, the Statute requires States to include newborn days, days in specialized wards, and administratively necessary days. States, in computing the Medicaid utilization rate for a particular hospital, are also to account for days attributable to individuals eligible for Medicaid in another State.

It is important to note that the numerator of the MUR formula does not include days attributable to Medicaid patients between 21 and 65 years of age in institutions for Mental Disease (IMDs). These patients are not eligible for Medical Assistance under the State Plan for the days in which they are inpatients of IMD's and may not be counted as Medicaid days in computing the Medicaid utilization rate.

The new limitation on qualification does not require that disproportionate share facilities meet the one percent threshold in the payment year. Rather, they must meet the one percent limit in the cost report period ending in the previous state fiscal year for which the State's Medicaid Plan determines disproportionate share qualification.

STATE Arkansas
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SUPERSEDES: TN • 95-15